This application is for medical insurance only.
If you want to apply for other benefits (like Basic Food), call 1-877-543-7669

?

- ☐ Did you enclose proof of income for the last 30 days?
- ☐ Did you sign the application?
- ☐ ☐ Did you fill in social security numbers for all children applying?
- ☐ ☐ If your children are non-citizens, did you attach a copy of their documentation?

For fastest service, please make sure application is complete.

WASHINGTON STATE HEALTH CARE AUTHORITY
PO BOX 45531
OLYMPIA WA 98599-9840

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO. 941 OLYMPIA WA
POSTAGE WILL BE PAID BY ADDRESSEE

NO POSTAGE NECESSARY IF MAILED IN THE UNITED STATES

Income Enter GROSS pay (before taxes or expenses). Please attach proof of recent income.

11. PARENT'S EMPLOYER NAME	TELEPHONE NUMBER ( )	START DATE

12. Amount you receive monthly before taxes and expenses are taken out: $

13. SPOUSE'S (OR OTHER PARENT LIVING IN THE HOME) EMPLOYER NAME	TELEPHONE NUMBER ( )	START DATE

14. Amount your spouse (or other parent living in the home) receive monthly before taxes and expenses are taken out: $

* If self-employed, you may verify income and expenses with your most recent tax return, including all schedules and attachments if it represents current/projected income.

Other Household Income	Average Amount Received Monthly	Which Family Member Earns This Income?	Other Household Income	Average Amount Received Monthly	Which Family Member Earns This Income?
15. Child Support/Alimony	$		16. Social Security Payment	$	
17. Unemployment Benefits	$		18. Veterans' Benefits	$	
19. Labor & Industries	$		20. Investment Income (Interest/Dividends)	$	
21. Other (Please Explain):				$	

Health Insurance Information Tell us about any health insurance your children already have.

22A. Do any of the **children** you are applying for already have health insurance? ☐ Yes ☐ No	22B. If "Yes," does that health insurance cover doctor, hospital, x-ray (radiology), and laboratory services? ☐ Yes ☐ No	23A. Have your **children** been covered by job-related health insurance in the last 4 months? ☐ Yes ☐ No	23B. If "Yes," list the monthly amount of premium for children: $

24. If you checked "Yes" to any of the above questions (22 A or B, or 23 A or B), please list the name of the insurance company or employer providing health insurance for your children.

INSURANCE COMPANY OR EMPLOYER	POLICY NUMBER	POLICY HOLDER'S NAME	POLICY HOLDER'S SOCIAL SECURITY NUMBER (OPTIONAL)

Optional Authorized Representative (Someone you allow the department to talk with about your benefits/receive letters).

If you would like to name a representative select one option below and complete representative information.

☐ Talk with the agency about your benefits; receive no letters. ☐ Talk to the agency about your benefits and receive letters.

NAME/ORGANIZATION			TELEPHONE NUMBER ( )
MAILING ADDRESS	CITY	STATE	ZIP CODE

Read Carefully Before Signing

This application is for medical benefits for children only. If anyone in your family already receives, or would like to apply for cash benefits, basic food, or other benefits, please contact your local DSHS Community Services Office (CSO).

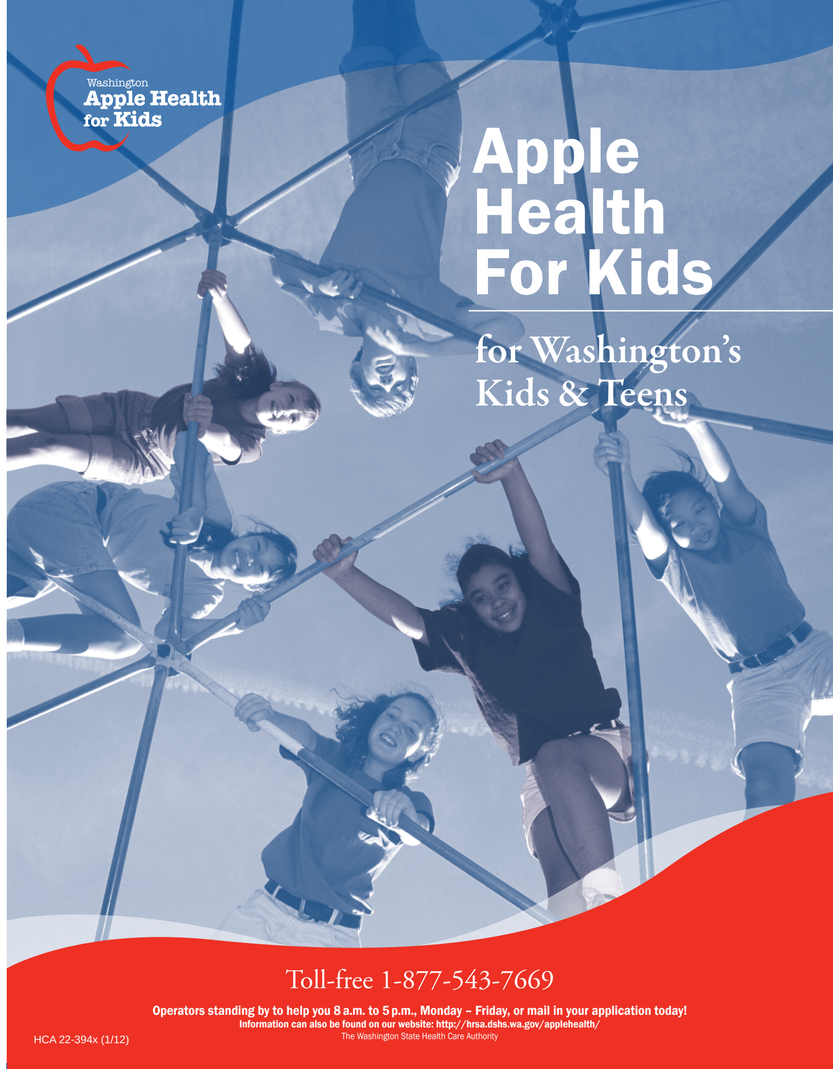
- The Agency or the Agency's designee may ask you to prove the information you are giving them to tell if you are eligible. You can ask the Agency or the Agency's designee for help in getting proof.
- Your information may be reviewed by other state or federal agencies. This information will NOT be shared with Immigration and Naturalization Services (INS).
- By asking for and getting health care benefits, you give the state of Washington all rights to any medical support and to any third party payments for health care.
- The Agency may share your child's immunization history with the Child Profile Immunization Tracking System.

DECLARATION AND SIGNATURE

I have read and understood the information in this application. I declare, under penalty of perjury, the information I have given in this application is true, correct, and complete to the best of my knowledge.

SIGNATURE OF APPLICANT	DATE

HCA 14-380 (1/12)



Washington Apple Health for Kids

Apple Health For Kids

for Washington's Kids & Teens

Toll-free 1-877-543-7669

Operators standing by to help you 8 a.m. to 5 p.m., Monday – Friday, or mail in your application today!
Information can also be found on our website: http://hrsa.dshs.wa.gov/applehealth/
The Washington State Health Care Authority

HCA 22-394x (1/12)

1. Thousands of Kids Under 19 are Eligible

Apple Health For Kids covers kids and teens in many types of households.

- Kids with single parents
- Kids with working parents
- Kids living with grandparents, other family, or friends
- Kids with two parents
- Young adults (under 19) living on their own

Even kids with pre-existing medical conditions qualify.

2. What Kinds of Services are Covered?

Apple Health For Kids covers a full range of services that all children need to stay healthy. Once your child is eligible, you will get more information on how to get care.

A few services that are covered include:

- Doctor and nurse visits
- Dental care
- Check-ups and immunizations
- Physical and speech therapy
- Transportation for office visits
- Hospital and emergency care
- Prescriptions
- Eyeglasses and hearing aids
- Family planning
- Counseling and more!

3. How Do I Find Out if My Kids Qualify?

The process is easy and many working families qualify. Income, family size (*be sure to include a pregnancy as a family member*), and some monthly expenses are reviewed for eligiblity. To see if your kids might qualify, follow the easy steps below. Then compare your monthly income to the chart below.

Step 1 **Write Down Your Family's Monthly Income (before tax)**

- **Subtract any monthly work-related child or adult care expenses you pay.** $ _____
- **Subtract all monthly court ordered child support payments you pay for a child living outside the home.** – _____
- **Subtract $90 for each working adult in the household.** – _____

Step 2 **Compare to See if You Qualify**

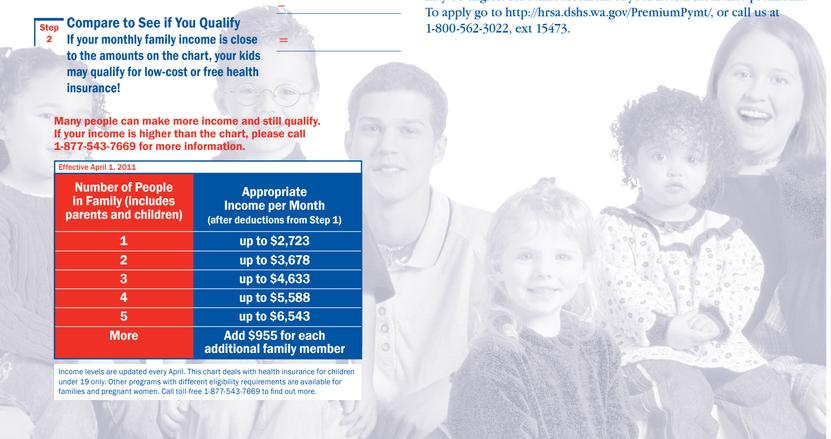
If your monthly family income is close to the amounts on the chart, your kids may qualify for low-cost or free health insurance! = _____

Many people can make more income and still qualify. If your income is higher than the chart, please call 1-877-543-7669 for more information.

Effective April 1, 2011

Number of People in Family (includes parents and children)	Appropriate Income per Month (after deductions from Step 1)
1	up to $2,723
2	up to $3,678
3	up to $4,633
4	up to $5,588
5	up to $6,543
More	Add $955 for each additional family member

Income levels are updated every April. This chart deals with health insurance for children under 19 only. Other programs with different eligibility requirements are available for families and pregnant women. Call toll-free 1-877-543-7669 to find out more.



1. Applying is Easy!

1. Fill out the application attached to this brochure.
2. Tear off the application page.
3. Detach the envelope from the application.
4. Attach copies of proof of income to the application. For example:
   - Pay stubs that represent current monthly income;
   - For self employment you may send in your most current tax return including Schedule C; OR
   - A letter from your employer giving your gross monthly income.
5. Put the application inside the envelope.
6. Drop in any mail box! No stamp is needed.

2. How Soon Will My Kids Have Health Coverage?

- Kids are considered for free health coverage first.
- You will get a letter within 6 weeks letting you know if the coverage is approved.
- When your kids are approved, they can get health care services immediately.
- For faster processing, be sure to fill out the application completely, and attach proof of income.
- Every twelve months we will mail you a form to renew their coverage for another year.

1. Apple Health For Kids

Coverage is Low Cost or Free

- Depending on your income.
- Kids are considered for free coverage first.
- Premiums are billed monthly, as low as $20 a month per child.
- If you have three kids or more, you'll only pay for two premiums.
- Some coverage may be retroactive, applying to unpaid bills up to three months old.

1. Apple Health For Kids

Premium Payment Program

If your child qualifies for the Free Apple Health for Kids program, you may be eligible for reimbursement of your health insurance premiums. To apply go to http://hrsa.dshs.wa.gov/PremiumPymt/, or call us at 1-800-562-3022, ext 15473.

Washington State Health Care Authority

Application for Apple Health for Kids Benefits

Washington Apple Health for Kids

This application is for medical coverage only for children and teens under 19. If you have questions or would like help filling out this form, just call 1-877-543-7669. We'll be happy to help you! Mail completed application to MEDS, PO Box 45531, Olympia, WA 98504-5531.

(List parent, guardian, or contact person who will receive follow-up information.)

1. FIRST NAME	MIDDLE INITIAL	LAST NAME		
2. ADDRESS WHERE YOU LIVE	STREET	CITY	STATE	ZIP CODE
3. MAILING ADDRESS (IF DIFFERENT)		CITY	STATE	ZIP CODE

4. HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER	MESSAGE TELEPHONE NUMBER	E-MAIL ADDRESS
( )	( )	( )	

5 Is everyone applying for benefits a Washington State resident? ☐ Yes ☐ No
If no, list who is not a resident:

6. Do you have trouble speaking, reading, or writing English and need an interpreter? ☐ Yes ☐ No
What language or alternative format do you need?

7. Do you need help paying for unpaid medical bills within the last 3 months for any of the children you are applying for? ☐ Yes ☐ No

8. Is anyone in your home pregnant? ☐ Yes ☐ No If yes, who? Due Date:

General Information

9. List family members **living together.** (If needed, attach a separate sheet of paper to list more family members).

NAME (FIRST, MIDDLE, LAST)	SEX M/F	RELATION TO YOU	BIRTH DATE (MM/DD/YY)	OPTIONAL FOR NON-APPLICANTS: SOCIAL SECURITY NUMBER	CHECK IF DOCU-MENTED ALIEN	CHECK IF U.S. CITIZEN	RACE *(see samples below)	TRIBE NAME (For American Indians, Alaskan Natives)
A. Parent, Guardian, or Self					☐	☐		
B. Spouse or Other Parent (If living in the home)					☐	☐		
C. List Children & Teens Under 19 Years of Age **(who want medical benefits)**					☐	☐		
D.					☐	☐		
E.					☐	☐		
F.					☐	☐		
G. List Any Adult/Child in the Home who does not want medical benefits.								

* Race and Ethnic background information is voluntary. Race examples: White, Black or African American, Asian, Native Hawaiian, Pacific Islander, American Indian, Alaska Native, or any combination of races. This information will not be used in considering your eligibility for benefits.

Expenses This information can help your children qualify. Do you pay the following expenses?

10. Do you pay for childcare or adult dependent care while you work, or do you pay court ordered child support for a child who is not living in your home? ☐ Yes ☐ No
If yes, how much per month? $ For who?

HCA 14-380 (1/12)

Barcode label

14380